THE CALIFORNIA REPORT ON CORONARY ARTERY BYPASS GRAFT SURGERY

1999 Hospital Data

Summary Report

August 2003

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Additional copies of the Summary Report can be obtained through the PBGH (www.pbgh.org) and OSHPD (www.oshpd.state.ca.us) Web sites. PBGH posts the hospital performance results on its California Consumer HealthScope Web site (www.healthscope.org), a public source of information on healthcare quality for California consumers.

PREFACE

August 2003

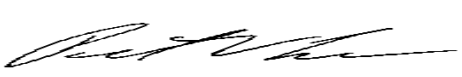
We are pleased to release ***The California Report on Coronary Artery Bypass Graft Surgery: 1999 Hospital Data*****,** the second report from the California Coronary Artery Bypass Graft (CABG) Mortality Reporting Program (CCMRP). The report reflects the continuation of an important partnership between the state, purchasers, and hospitals to voluntarily collect and release hospital performance data on mortality associated with coronary artery bypass graft surgery. In an environment of scarce resources, collaboration is critical.

Data on 70 of the 119 hospitals that regularly performed bypass surgery in 1999 are summarized in this report. These 70 hospitals performed approximately 68% of all isolated coronary artery bypass graft surgeries in California in 1999. For the 1999 analysis period, the overall in-hospital death rate for bypass surgery was 2.76% among the participating hospitals.

All 70 participating hospitals are to be commended for their explicit commitment to quality improvement—for which measurement and public accountability are requisite steps in the quality improvement process. The transparency of hospital performance information is critical to national efforts to close the quality gap identified in the Institute of Medicine's report *Crossing the Quality Chasm* (2001). Through concerted, collaborative efforts to measure and reduce performance variations, we can take concrete steps to ensure that the care provided by California hospitals is safe, effective, and efficiently delivered.

The important work of CCMRP over the last five years, which laid the foundation for public reporting of CABG outcomes and highlighted differences in death rates between participating and non-participating hospitals, set the stage for compulsory reporting of bypass surgery outcomes for hospitals and surgeons in California. The passage of Senate Bill 680 (Chapter 898, Statutes of 2001) replaces CCMRP with the California CABG Outcomes Reporting Program (CCORP) operated by OSHPD. CCORP begins its data reporting with the 2003 hospital data submission; meanwhile, CCMRP continues its work to close out the 2000-2002 data period.

Through this important partnership, our goal is to produce information that will be used to improve health outcomes for all patients who undergo bypass surgery, regardless of the hospital that they and their physicians select. To do so requires that we have knowledge about performance and that we apply this knowledge to drive improvements in the quality of care and reward those institutions that have demonstrated excellence in performance.



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The California CABG Mortality Reporting Program reflects the efforts and significant contributions of numerous individuals, including:

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